Workload Standardization & Data Quality

John H. Varga, MD, FACS

Commander, Medical Corps, U.S. Navy

Director, Financial Analysis & Integration (RM/TMA)

Workload Standardization Work Group

- Chartered - March 1999
- Representatives:
  - HPA&E
  - HA/HB&FP
  - RM/FA&I
  - MHSO
  - PASBA
  - MEPRS

FY 99 and before . . .

- Inpatient Workload: DRGs
- Outpatient Workload: MEPRS work center

New Direction

- Align MHS workload measurement with civilian standard
  - Bill professional and facility charges separately
  - Discrete Encounters vs. Stays
- More accurately measure what we really do
- Better documentation for various programs
  - MCSC (Director Care vs. Network)
  - TRICARE Senior Prime
  - Third Party Collections

Inpatient workload in DRGs

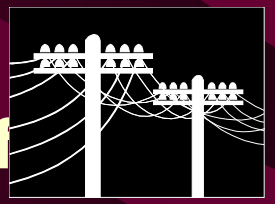
- Includes provider component, despite mismatch
- No low end boundary for non-hospital care (highest volume DRG at West Point and the USAF Academy is “Tooth Extraction”)

Outpatient workload in MEPRS visits

- Bundles facility and provider components
- Cost and complexity of care are not workload drivers -- only the location providing care matters
- Arbitrary types and “countable” implementation at MTF or clinic level
- Same day surgery identification flawed
- No recognition of newer venues or services

FY 00 Workload Standardization

- Separation of clinician/provider workload from facility burden of support



- Recognition of newer services and venues

Measuring Provider Workload

Inpatient

Clinic visit

Telemedicine

External resource share

Home health

Same day surgery

Work is tallie in CPT & HCPCS RVUs

Provider Changes

- Current standard outpatient encounters unchanged
- New venues - require new methodology
  - Telemedicine (2 locations involved)
  - Home Health (non-standard facility support)
  - SDS (requires standardization)
- Inpatient - new and additional requirements

Inpatient

- ADS entry for each “meaningful” encounter
  - daily rounds
  - procedures
  - additional visits by attending
  - consults
- Education - accuracy of CPT coding
- Compliance - similar to outpatient ADS

Measuring Facility Workload

Outpatient

Clinic visit

Telemedicine

External resource share

Home health

Same day surgery

Work is tallied in Ambulatory Patient Groups (APG) RVUs

The same data recorded by the clinician generates the APGs.

Measuring Facility Workload

Inpatient

Hospital
Skilled Nursing
Hospice
Minimal

Work is tallied in DRGs and days of stay by setting

Business Practice Changes

Clinician

- Record all encounters
- Good diagnoses
- Good procedures

Administration

- Build setting flags
- Build setting cost centers
- “Countable visits” maintained as is (BPA)
- Management of completion quality

Encounter Recording

- Every significant provider service
- No generic providers
- Normal completion of ADS
- Greater use of HCPCs
- Special Cases

Special Cases

- Care away from the provider's facility
  - Home health
  - Telemedicine
  - External Facility

Special Cases

- **Workload Credit** **Provider** **Facility**
  - **Home Health** **CPT** **APG**
  - **Telemedicine - Consultant** **CPT** **---**
  - **Telemedicine - Requestor** **CPT** **APG**
  - **External Facility** **---** **APG**
  - **External Provider** **CPT** **---**

Special Cases for Non-Hospital Stays

- **Identified by using Admitting MEPRS code**

Special Care Type	MEPRS
Hospice Care	AZA
SNF-Level Care	AZB
Minimal Care	AZC
(Observation Care*	AZD)

***Reserved, not used in FY 00**

Facility Changes

- New “work center” designations
  - Home Health
  - Hospice
  - Skilled Nursing
  - Minimal
  - Observation
  - Case Management
  - Self-Care
- Does not imply certification

Implementation

- FY 00
  - changes cannot require SCR or major IM/IT changes
  - implemented by business rule changes
  - will require education/training
  - learning curve understood
- Long Term
  - More ideal solutions planned

RCT GUIDANCE

- **STRONGLY SUPPORTIVE**
- **RECOGNIZE RESISTANCE MAY COME:**
  - **From clinicians asked to record encounters**
  - **From those against ADS (or KG-ADS)**
  - **From IM/IT foreseeing new requirements**
- **IMPLEMENTATION PLANNING NEEDED**

KEY ACTIONS AHEAD

- UBO National Conference (3 Aug)
- MEPRS/MMIG Monthly Meeting (Aug)
- UBU Policy and Detail Release (1 Aug?)
- CEIS Interim Provider Reporting (1 October)
- IM/IT Improvements to ADS (ongoing)
- PAD Channels for Business Practice changes
- Central Processing Tables & Software Builds

Data Quality

- GIGO
- Audits
  - GAO
  - DoDIG
  - Congress
  - HCFA
- Bid Price Adjustments - TRICARE contracts
- Must have accurate data in <u>All</u> areas

What Are The Problems

- Confusion on Encounter Vs Visit Definition
- Non-count items are being counted
- Inconsistent MTF Compliance
- Training Issues
- Differences between regional IDBs and Ft Detrick data
- Summary visit data differs between systems

Ways to Deal with Problems

- TMA Visibility of MTF Performance
- Prescribe Method to Achieve Compliance
  - Ad-Hoc CHCS and Business Objects Reports
  - Better Information Sharing (between MTFs)
  - Tri-Service Collaboration
- Develop Standardized Data Quality Metrics

MEPRS Data

MTF Transmission Listing With Percentage Complete				DATA on		(Should have 6 mo	
Army FY-99				5/10/99		(Should have all M	
		1	2	3	4	5	6
Parent Installation Name	Parent DMIS ID	Oct	Nov	Dec	Jan	Feb	Mar
REDSTONE ARSENAL	1	1	0	0	0	0	0
FT. MCCLELLAN	2	1	1	1	1	1	0
FT. RUCKER	3	1	1	1	1	0	0
FT. WAINWRIGHT	5	0	0	0	0	0	0

		1	2	3	4	5	6	7
Parent Installation Name	Parent DMIS ID	Oct	Nov	Dec	Jan	Feb	Mar	Apr
MAXWELL AFB	4	1	1	1	0	0	0	0
ELMENDORF AFB	6	1	1	1	1	1	1	0
LUKE AFB	9	1	1	0	0	0	0	0
DAVIS MONTHAN AFB	10	1	1	1	1	1	1	0
LITTLE ROCK AFB	13	1	1	1	1	1	1	0
TRAVIS AFB	14	1	1	1	1	1	0	0

		1	2	3	4	5	6	7
Parent Installation Name	Parent DMIS ID	Oct	Nov	Dec	Jan	Feb	Mar	Apr
NH CAMP PENDLETON	24	0	0	0	0	0	0	0
NMCL PORT HUENEME	26	0	0	0	0	0	0	0
NH LEMOORE	28	1	1	1	0	0	0	0
NMC SAN DIEGO	29	1	1	1	0	0	0	0
NH TWENTYNINE PALMS	30	0	0	0	0	0	0	0
NACC GROTON	35	0	0	0	0	0	0	0

ADS Compliance Data Over Doing It

	Mar 98			Apr 98		
CLINIC	**WKLD**	**SADR**	**COMPL**	**WKLD**	**SADR**	**COMPL**
BAA-INTMED	2561	2450	95.7%	2757	2609	94.6%
BAB-ALLERGY	633	539	85.2%	843	656	77.8%
BAC-CARDIO	**137**	**642**	**468.6%**	**165**	**689**	**417.6%**

ADS Compliance Data
Single Element Fallout

	Apr 98			May 98		
CLINIC	**WKLD**	**SADR**	**COMPL**	**WKLD**	**SADR**	**COMPL**
BHB-MED EXAM	559	609	108.9%	479	435	90.8%
BHC-OPTOMETRY		**948**	**936**	**98.7%**	**0**	**939**
NA						
BHD-AUDIOLOGY	824	801	97.2%	646	641	99.2%

ADS Compliance Data
Half-way Done
No SADR's

	Mar 98			Apr 98		
CLINIC	WKLD	SADR	COMPL	WKLD	SADR	COMPL
BHA-PRIMARY CARE	527	0	0.0%	481	0	0.0%
BHG-OCC HEALTH	157	0	0.0%	147	0	0.0%

Third Party Claims

- Rejected claims may be due to missing, incomplete or incorrect data
- Rejected claims = $$
- Therefore, poor data = $$

SIDR Common Problems

- Improper MEPRS Codes
- Demographic Input Errors
  - D Codes not mapped to A Codes
  - PATCAT inconsistent with FMP
  - PATCAT 22, 23, 24 Problem
  - DOB Incorrect
  - Invalid SSN
  - Invalid Zip Code
- IPDS Transmittal Problems
- Provider Profile lacks proper MEPR Codes

Recommendations

- Identify and Involve Key Players
  - Managed Care
  - Resource Management
  - Patient Administration
  - Credentials
  - Data Quality Manager
- Focus on Key Metrics---Standardize!!!
- Form Users Groups
- Use Higher HQ Resources
  - Service Informatics POCs
- Communicate!!!!

Data Quality Information Sources

- EBC Website
  - http://www.tricare.osd.mil/ebc/
- PASBA Website
  - http://pasba.tricare.osd.mil/pasba/dqfas.html
- CEIS Homepage
  - http://www.ceis.ha.osd.mil
- Reconciliation Data-ACCESS Data Base
  - Query to EBC Scorecard monthly

QUESTIONS?